

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
DIAGNOSIS AND ICDE 10 CODE		
<input type="checkbox"/> Moderate to Severe Rheumatoid Arthritis (RA)	ICD 10 Code: M 06.9	
<input type="checkbox"/> Active Ankylosing Spondylitis	ICD 10 Code: M45.9	
<input type="checkbox"/> Active Psoriatic Arthritis	ICD 10 Code: L40.52	
<input type="checkbox"/> Other: _____	ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment		<input type="checkbox"/> Clinical/Progress notes (must be within 1 year)\ <input type="checkbox"/> Labs and tests supporting primary diagnosis <input type="checkbox"/> TB Test results <input type="checkbox"/> Hepatitis B results: ABsAG, Total HepB Core Antibody
List of tried and failed therapies, including duration of treatment:		
1) _____		
2) _____		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____		
Initial Dose	<input type="checkbox"/> J1602 Simponi Aria 2mg/kg IV at week 0, 4 then every 8 weeks thereafter	
Maintenance Dosing	<input type="checkbox"/> J1602 Simponi Aria 2mg/kg IV every 8 weeks <input type="checkbox"/> Other: J1602 Simponi Aria _____ IV at every _____ weeks	
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
PREMEDICATIONS/ LAB ORDERS		
<input type="checkbox"/> Acetaminophen _____ mg PO PRN		<input type="checkbox"/> CBC <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____
<input type="checkbox"/> Benadryl _____ mg PO or IV		<input type="checkbox"/> CMP <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____
<input type="checkbox"/> Methylprednisolone _____ slow IV push		<input type="checkbox"/> Other: _____ Date: _____
<input type="checkbox"/> Other: _____		
ADDITIONAL ORDERS/INFORMATION		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – SIMPONI ARIA (GOLIMUMAB)